



**New Patient Intake Form**

Patient Demographic Details				
Name:		DOB:	SSN:	
Home Phone:	Mobile Phone:		Email:	
Address:		City:	State:	Zip Code:
Primary Care Provider:		Practice:	Phone:	
Referring Provider:		Practice:	Phone:	
Pharmacy:	Phone:	Mail-Order Pharmacy:	Phone:	

**Acknowledgement of Receipt of Notice of Privacy Policies**

I hereby acknowledge that I have received a copy of Beacon Cancer Care’s Notice of Privacy Practices and have had an opportunity to read and ask questions about the same.

\_\_\_\_\_  
 Signature of Patient/Legally Authorized Representative

Date: \_\_\_\_\_

\_\_\_\_\_  
 Printed Name of Patient/Legally Authorized Representative

Relationship: \_\_\_\_\_

Please note: You may refuse to sign this Acknowledgment.

*For Office Use Only*

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Policies, but acknowledgment could not be obtained because:

- Communication barriers prohibited obtaining the acknowledgment
- Individual refused to sign
- An emergency situation prevented us from obtaining acknowledgment
- Other: \_\_\_\_\_

\_\_\_\_\_  
 Signature of Staff Member

Date: \_\_\_\_\_



980 W. Ironwood Dr., Ste. 207  
Coeur d'Alene, ID 83814

## Notice of Privacy Policies

### **YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

### **YOUR RIGHTS**

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

### **YOUR CHOICES**

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

### **OUR USES AND DISCLOSURES**

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

### **YOUR RIGHTS**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

#### **Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

#### **Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

#### **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

### **Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

### **Get a list of those with whom we’ve shared information**

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

### **Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

### **Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

### **File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

## **YOUR CHOICES**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

## **OUR USES AND DISCLOSURES**

### **How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

#### **Treat you**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

#### **Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

#### **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

### **How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

### **Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

### **Do research**

We can use or share your information for health research.

### **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

### **Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

### **Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

### **Address workers’ compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers’ compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

### **Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

### **OUR RESPONSIBILITIES**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

### **CHANGES TO THE TERMS OF THIS NOTICE, EFFECTIVE DATE AND OTHER INFORMATION**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and in our office. This Notice is effective as of August 23, 2018. Beacon Cancer Care intends to comply with all HIPAA Regulations currently in effect. Please direct questions about this Notice to the Practice Administrator at (208) 755-2804.



980 W. Ironwood Dr., Ste. 207  
Coeur d'Alene, ID 83814

### HIPAA Release Form

I, \_\_\_\_\_, hereby authorize the use and disclosure of my protected health information, as more particularly described below, to:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Contact Information: \_\_\_\_\_

Health information to be disclosed upon the request of the person named above -- (check either A or B):

A. Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions); **OR**

B. Disclose my health record, as above, **BUT do not disclose** the following (check as appropriate):

- Substance abuse
- Psychiatric (mental health)
- Communicable diseases (including HIV and AIDS)
- Genetic testing
- Other (please specify): \_\_\_\_\_

Form of Disclosure (check one or both):

- An electronic record or access through an online portal
- Hard copy

Purpose for Use or Disclosure: \_\_\_\_\_

Unless I revoke it, this authorization shall be effective until (check one):

- All past, present and future periods; **OR**
- Date or event: \_\_\_\_\_

I understand that I may revoke the authorization at any time by submitting a written request to: Beacon Cancer Care, 980 W. Ironwood Drive, Ste. 207, Coeur d'Alene, ID 83814. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

\_\_\_\_\_  
Signature of Patient/Legally Authorized Representative

Date: \_\_\_\_\_

\_\_\_\_\_  
Printed Name of Patient/Legally Authorized Representative

Relationship: \_\_\_\_\_



980 W. Ironwood Dr., Ste. 207  
 Coeur d'Alene, ID 83814

### Patient Health History Form

Name of Patient: \_\_\_\_\_

Patient's DOB: \_\_\_\_\_

<u>Personal Cancer History</u>				
Type of Cancer:	Year Diagnosed:	Treatment Received:		
1.)				
2.)				
<u>Chronic Medical Conditions:</u>		Year Diagnosed:	Managing Physician:	
1.)				
2.)				
3.)				
4.)				
Current Medications:	Dosage:	Frequency:		
1.)				
2.)				
3.)				
4.)				
<u>Allergies:</u>		<u>Reaction:</u>		
1.)				
2.)				
3.)				
4.)				
<u>Social History</u>				
Marital Status: _____		With whom do you live? _____		
Do you have a history of smoking tobacco (this includes smokeless tobacco)? _____ How many packs did/do you smoke per day? _____ Date you quit: _____ Total years you smoked: _____		Do you drink alcohol? _____ If yes, how many drinks per week? _____ _____ If you used to drink, when did you stop? _____ Do you use drugs? _____ If yes, what drugs do you use and how often? _____ _____		
<u>Family Cancer History</u>		Relationship to You:	Age at Diagnosis:	Current Age/Age at Death:
Type of Cancer:				
1.)				
2.)				
3.)				
4.)				

Additional Information:

Date of last flu shot: \_\_\_\_\_ Date of last mammogram: \_\_\_\_\_

Date of last colonoscopy: \_\_\_\_\_ Date of last PET/CT Scan, MRI or other imaging: \_\_\_\_\_

## **Medication Refill Policy**

Please use these guidelines for planning your next medication refill:

1. If you fill your prescription through a **local pharmacy**, please call and leave a message for the appropriate medical assistant (see below) at least **five (5) days** before your medication is due to run out.
  - If you are a patient of Dr. Samuels or Noelle Beierle, please call Shelli at (208) 755-2804 ext. 204.
  - If you are a patient of Dr. Bartels, please call Vickie at (208) 755-2804 ext. 206.
2. If you fill your prescription through a **mail-order pharmacy**, please call and leave a message for Nicole at (208) 755-2804 ext. 207 at least **fourteen (14) days** before your medication is due to run out.
3. If you need an urgent refill request (within 24 hours), please call the front desk at (208) 755-2804 ext. 0 to expedite the refill process. Please allow the medical assistant to get back to you by the end of the business day.

*Thank you for your cooperation. Please let us know if you have any questions.*

### Grant / Co-Pay Assistance

At Beacon Cancer Care, we make it a priority to provide any available financial assistance to our patients. If you would like to provide your personal information below, we will look for available grants and/or co-pay assistance opportunities related to your diagnosis. We keep this information confidential and will only share it with the grant issuer and/or co-pay assistance organization.

*By signing below, I hereby authorize Beacon Cancer Care to apply for financial assistance opportunities on my behalf without any further notification or permission required.*

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Household Size: \_\_\_\_\_ Annual Income: \_\_\_\_\_

\_\_\_\_\_  
 Today's Date: \_\_\_\_\_

**Signature of Patient/Legally Authorized Representative**

### Foundations

There are numerous grant and co-pay assistance opportunities available for many oncology and hematology diagnoses. Here is a non-exhaustive list of foundations we consider for potential opportunities:

Patient Access Network Foundation

[www.panfoundation.org](http://www.panfoundation.org)

1-866-316-7263

Lymphoma & Leukemia Society

[www.lls.org](http://www.lls.org)

1-877-557-2672

Patient Advocate Foundation Copay Relief

[www.copays.org](http://www.copays.org)

1-866-512-3861

The Assistance Fund

[www.tafcares.org](http://www.tafcares.org)

1-855-845-3663

Healthwell Foundation

[www.healthwellfoundation.org](http://www.healthwellfoundation.org)

1-800-675-8416

Patient Services Inc.

[www.patientservicesinc.org](http://www.patientservicesinc.org)

1-800-744-9388

CancerCare

[www.cancercarecopay.org](http://www.cancercarecopay.org)

1-866-552-6729

Good Days

[www.mygooddays.org](http://www.mygooddays.org)

1-877-968-7233

## Financial Policy and Consent for Billing

Name of Patient: \_\_\_\_\_ Patient's DOB: \_\_\_\_\_

We ask that you read through this financial policy and sign the bottom prior to treatment.

### Financial Policy:

I understand my insurance company will be billed on my behalf, and I am responsible for all fees, deductibles, co-payments and any unpaid portion of my bill. Payment in full is due at time of service, including full payment for self-pay patients, unless other arrangements have been made. We accept cash, credit card or check. There will be a service charge of the lesser of \$20.00 or the face amount of the check on any returned check.

*Note: Please provide your insurance card and, if applicable, your pharmacy card upon check-in. Patients who do not supply accurate insurance information will be considered self-pay.*

We participate with a number of medical insurance plans that we will contact to verify eligibility and benefits. Please understand that you have the ultimate responsibility of verifying the coverage with your insurance. You acknowledge that we may be an out-of-network provider with your insurance. If your plan requires a referral from your primary care provider, it is your responsibility to obtain it before seeking treatment from us. If a claim is denied due to lack of referral, you understand you may be responsible for the charges. You must inform our office of any changes in your insurance, as you are the policyholder and it is ultimately your responsibility.

If you are unable to keep your appointment you must notify the office at least 24 hours prior to your scheduled appointment as a courtesy to the providers, staff and other patients. If you cancel or "no-show" without sufficient notice, you may be subject to a fee, payable by you, not your insurance company.

### Authorization and Release:

I authorize and request my insurance company to pay directly to Beacon Cancer Care, PLLC any insurance benefits otherwise payable to me.

I understand that my insurance carrier may deny or pay less than the actual bill for services, and I agree to be responsible for any remaining balance.

\_\_\_\_\_  
Signature of Patient/Legally Authorized Representative

Date: \_\_\_\_\_

\_\_\_\_\_  
Printed Name of Patient/Legally Authorized Representative

Relationship: \_\_\_\_\_